



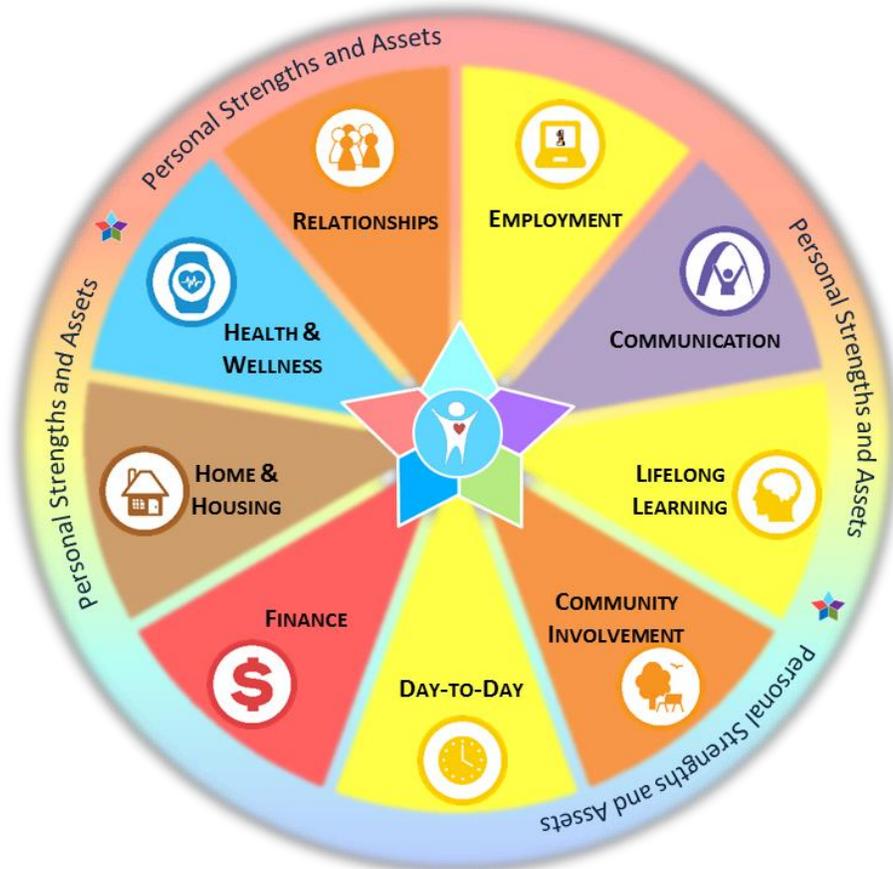
MARYLAND
Department of Health

Developmental Disabilities Administration

Exploration and Discovery for Development of the Person-Centered Plan



A Guide* for the Coordinator of Community Services



My Life, My Plan, My Choice...

***Statement of Purpose:** The intent of this guide is to offer an overview of the Developmental Disabilities Administration (DDA) vision for person-centered planning. Use of the guide presumes the CCS has been trained in the basic principles of person-centered thinking and is familiar with some of the most frequently used planning tools referenced herein. This guide is not intended to replace such training; but rather support a robust exploration and discovery process to identify what is most important to the person in a manner that can be effectively translated to the DDA Long-Term Services and Supports (LTSS) system for development of the person-centered plan.

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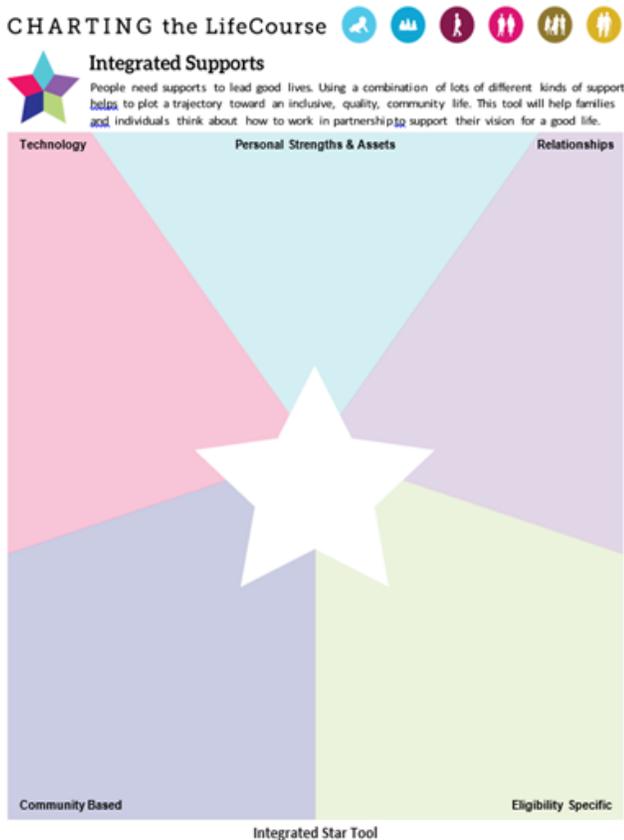
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INTRODUCTION AND OVERVIEW



Person-centered planning is a process that begins with the understanding that all people have the right to live, love, work, play and pursue their aspirations in their community. To that end, people have the right to figure out and pursue their *good life*¹. What defines a good life is as individual and unique as the person being supported. Many people also have family and others in their lives who play a meaningful role as the person explores potential interests and opportunities not considered before.

Although supports and needs may change across the lifespan, pursuit and enjoyment of what is **important to** the person remains the guiding force. Real person-centered planning provides a remarkable opportunity to guide (and sometimes cheer!) people through a process of discovery to learn what is most

“In order for people to have a good life, staff need to know what is important to them.”
 –Doris, Self-Advocate

¹ The National Community of Practice/Supporting Families LifeCourse Framework offers tools to help people at any stage of life to think about life as they want to live it. This individually described vision may be referred to as the person’s good life. <http://www.lifecoursetools.com/planning/>

important to them, and then partner to create a plan that supports a clear trajectory² toward their personally-defined good life.

This guide for the CCS suggests varied strategies that may be used in helping each person to consider their personal strengths, assets, gifts, and wishes across the Life Domains³ (cover page graphic) and over the lifespan. The process involves finding out how each person prefers to engage. It can be done through a one-to-one conversation, a meeting with family, friends, and/or others important to the person, a formal process such as the Integrated Star Tool, Essential Lifestyle Planning⁴ or PATH⁵, or, most often, a combination of approaches.

Exploration and Discovery⁶ means finding out who and what is important to the person with whom you are planning. Exploring important relationships, community connections, faith-based associations, areas of interest, and talents can also help to identify additional potential support for desired Outcomes.

Keep in mind that people have all kinds of relationships. It's important to understand the nature of these relationships and figure out how the person would like to involve others who are important to them in the planning process. Engaging fully and respectfully with people throughout planning can help to build the trust, respect, and high expectations needed for meaningful discovery to take place.

Meaningful Discovery is not made by checklist or inventory; it cannot be accomplished in a single meeting or visit. Exploration and Discovery is an ongoing process that occurs over the course of many interactions that may include casual conversation, discussion, and observation; it may be with the person served, with family members and/or with other people important to that person. The point is to ask and listen.

It may be that initial Discovery is about what is not happening; perhaps a lack of experience or exposure needed to support choice-making or to determine personal Outcomes. When these areas are identified, be prepared to discuss options and potential next steps. Keep in mind that the period of Discovery never really ends. In time, all team members will grow in their knowledge and understanding and become more attuned to the person's strengths, preferences and desires. As people grow and age, keeping these key relationships strong will mean ongoing Exploration and prompt response to changes in what they want/need to live their good life.

The Person-Centered Plan (PCP)

As a person explores and defines their personal good life, you may use one or more of the many tools and assessments that are available to support the information gathering process. Solid Exploration/Discovery supports identification of personally relevant Outcomes, which



² Trajectory is defined in this case as a path moving in a direction toward the good life as defined by the individual.

³ In the LifeCourse tools for developing a vision, categories are used to structure conversation and exploration; these Life Domains are the basis for those being used by Maryland in its PCP approach. <http://www.lifecoursetools.com/wp-content/uploads/Vision-Planning-Tool-updated-february-2017.pdf>

⁴ Essential Lifestyle Planning is a method developed by Michael Smull to discover and describe what is important to a person and what others need to do in support of those things while addressing health/safety. For more information, go to <http://www.learningcommunity.us/elp3.html> and <http://helensandersonassociates.co.uk/>.

⁵ PATH was developed by Jack Pearpoint, Marsha Forest and John O'Brien. When used in person-centered planning, the focus person and people invited meet with at least two facilitators to work through the process. For more information, go to <http://trainingpack.personcentredplanning.eu/index.php/en/map-and-path/path>.

⁶ Discovery and Exploration in the PCP is not the same as the waiver service **Employment Discovery and Customization** which are time-limited services designed to help the person access employment or explore the possibilities and impact of work.

guide team discussion of supports and services needed to help the person achieve those Outcomes, as well as a clear description of how the progress or milestones will look. For Outcomes related to DDA services, the service provider will work with the person to develop related goals with implementation strategies, while the CCS will monitor satisfaction and service delivery based on the agreed-upon progress descriptions.

Development of an informed, relevant and meaningful PCP can make a tremendous difference in the quality of the person's life. It is important that Discovery be shared with team members prior to the annual meeting so all are prepared to support the person's desired Outcomes. It is also important to use a person-centered approach in the written PCP:

- ✓ Language is respectful and person-first
- ✓ Terms are easily understood, not clinical or jargon
- ✓ There is clear indication of the person's talents, gifts, and preferences
- ✓ Easily identifies what is important TO the person: i.e., relationships, status, financial stability, rituals or routines, things to have or do

The Person-Centered Planning Process

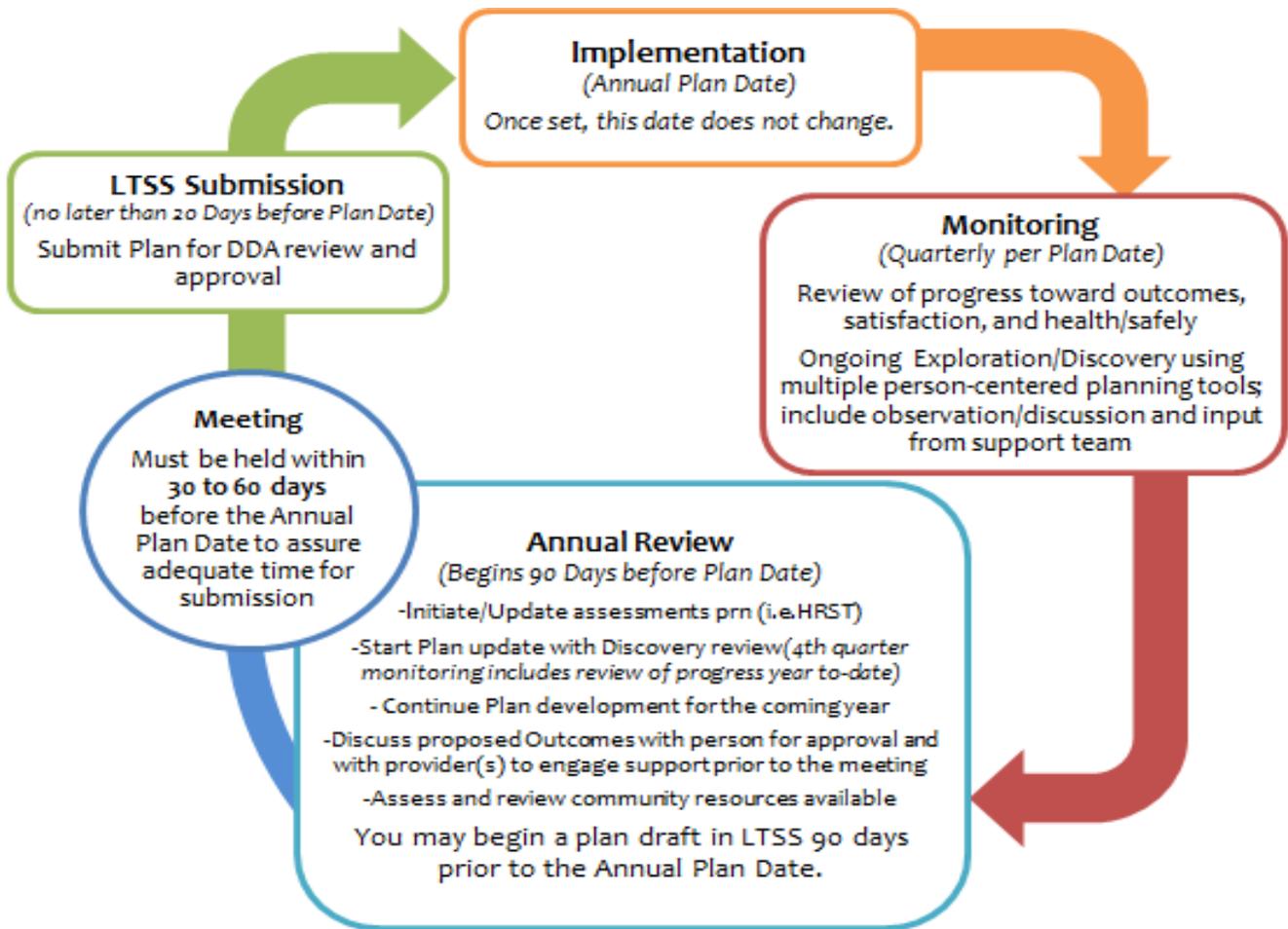
PCP is a continual process of listening and learning (Exploration and Discovery) to create a meaningful and relevant plan that may be adjusted according to life circumstances. While changes may be requested and revisions made throughout the year, the PCP date (month/day) remains the same from year to year.

“This is my life; put me in the driver's seat.”
— *Patrick, Self-Advocate*

The process for annual review and update of the PCP typically begins in the final quarter of the current PCP or 90 days before the plan date, with monitoring activities. As with all monitoring, progress on Outcomes, satisfaction with services and changes in needs are assessed. Additionally, the Health Risk Screening Tool (HRST) is updated at this time. Information gathered is carried forward as you take the next steps—contacting team members to schedule the annual meeting and conducting the annual review (see below). It is essential to begin this process early so the PCP is well-informed and relevant to what is most **important to** the person and to allow sufficient time for DDA review and approval prior to the PCP date. This becomes even more critical as the system begins using the PCP to authorize services for related provider invoicing.

Exploration/Discovery can be done face-to-face with the person alone or with others they want included. Typically, conversations are conducted without the direct service provider to allow for maximum opportunity to explore ideas for their good life without the constraint of fitting into a specific service model. This process may require a few or many discussions; it may involve observation and/or gathering information from others about people who use alternate means for communication. The methods and tools you use depend on factors such as how a person communicates, how well you know them, what is happening in their life, their availability and that of others important to them. Remember to ask questions and/or get clarification on what you discovered earlier in the process. In all cases, follow the person's lead!

As CCS, your planning efforts should prepare you to, as much as is needed, help the person articulate what they want in life. The provider is then able to work with them to figure out how they can best support Outcomes attainment through development of goals and strategies. It is also critical that the person and team members describe progress for each selected Outcome. These descriptions will be central to subsequent monitoring efforts and will help to determine, in a meaningful way, the effectiveness of PCP implementation.



Roles and Responsibilities of the Team

With this new process comes an increased opportunity for collaboration among the person's support team, as each entity has more clearly defined roles, meaning less confusion for all. First and foremost, the person is the owner of their PCP. This means no one else can make changes (unless there is a legal guardian). In the most basic terms:

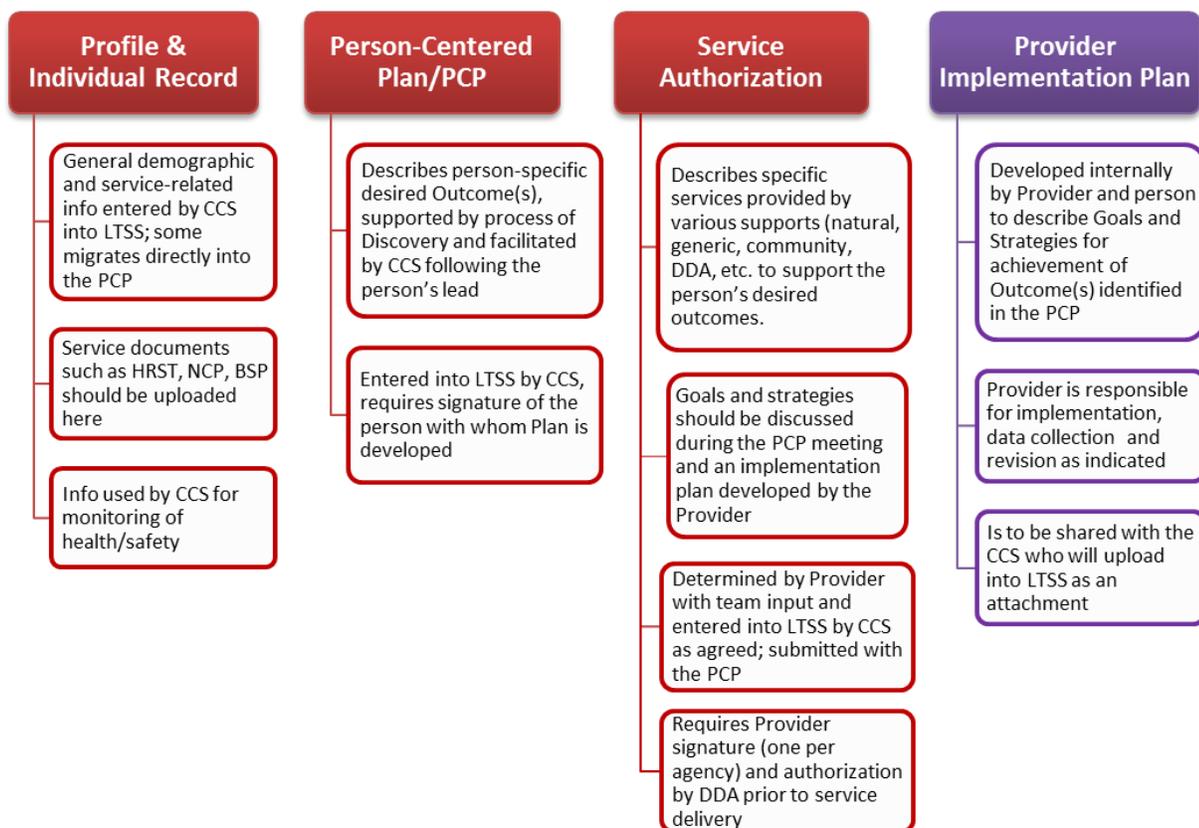
- Person supported:
 - Develops, with support from the CCS, their PCP and approves the Outcomes as stated
 - Informs any team member if changes are requested
- CCS
 - Ongoing **PCP Exploration and Discovery** to facilitate identification of desired Outcomes and helps the person articulate those Outcomes to the rest of the team
 - Creates the PCP as directed by the person in the DDA's LTSS system.
 - Assures timely submission of the complete PCP to the DDA
 - Monitors individual satisfaction with services, progress made toward Outcomes (using the defined milestones agreed on by the team) and health/safety assurances ultimately ensuring that the PCP is being implemented as developed and documented with the Quarterly Monitoring and Follow-up form
 - Facilitates revisions to the PCP as indicated by changes in needs or circumstances

- Service Provider
 - Identifies services to support the person’s desired Outcomes, to include frequency and scope, for the *Service Authorization*
 - Works with the person to develop goals and implementation strategies to achieve those Outcomes
 - Assures the *Provider Implementation Plan* meets the regulatory standard for measurable/observable goals and objectives
 - The *Provider Implementation Plan* is not a predetermined form, it is simply a label for the provider component of the service delivery process
 - Shares information with the CCS to further PCP development and need for PCP revision throughout the year
- DDA Regional Office
 - Reviews each PCP, including the Service Agreement, to provide authorization prior to implementation of services

How Components Come Together for a PCP

Each entity has a specific role to play and each is responsible for open communication with the others to ensure a greater degree of success.

This graphic below shows the flow of information into the LTSS database in red. The combined Individual Record/Client Profile, PCP, and Service Authorization information are all entered and/or updated and submitted by the CCS at least 20 days before the PCP date to assure sufficient time for review by the Regional Office. The *Provider Implementation Plan* should be uploaded to LTSS as an attachment. It is within the work scope of the service provider and maintained per their respective policies. It must be developed by the Provider soon after the annual meeting and submitted with the PCP for DDA authorization so service delivery can begin on the plan date.



The requirement for DDA approval of the PCP with Service Authorization prior to service delivery is the reason that the annual meeting must be held early enough (25-40 days before the annual plan date is best practice) to assure implementation readiness as of the plan date.



Exploration/Discovery – Focus Area Exploration (FAE):

Information learned during Exploration and Discovery is analyzed and filtered using the Life Domains in an LTSS format called the Focus Area Exploration or FAE. It is designed to summarize the breadth of information relevant to the person, support development of a concise PCP that accurately represents the individual in a person-centered manner and support individual choice and control in all aspects of planning. Information is revisited and revised to reflect changing preferences and interests as they develop.

To drive a person-centered approach, the FAE includes fields to capture discussion of what is working and what is not working in the person’s life, as well as supports that may be needed to address unmet needs or concerns. Through this process of Exploration, the CCS learns what is most important to and for the person as related to specific Life Domains. The guidance offered in this guide is intended for effective facilitation of Exploration and Discovery in areas that are relevant to the person at a particular time in life. It is not intended that all Domains are explored at once, and there is no expectation that information be completed for each Domain. Instead, what is learned should be entered into the relevant Domain, and in time, the ongoing nature of Exploration will result in a fully developed picture of the person at the center.

As you start using LTSS to organize information discovered, you may eventually find that additional material is presented under Important TO/FOR through third-party completion of the Supports Intensity Scale (SIS). This is another tool for use in assuring a broad base of understanding the person holistically and should be considered in PCP development.

What's Working for Me? (Abilities, Strengths, Preferences, Contributions, etc.)

What's Not Working for Me? (Unmet needs, Dislikes, etc.)

What Supports do I Need?

Important TO/FOR Me:

Important TO Me	Important FOR Me

Risks

Risk Name	Description	How Addressed	Rights Restriction

The PCP Documents

The printed PCP document for sharing begins with a Summary that includes basic information from the Client Profile and PCP specifics such as dates, introductory statements shared by the person, list of Outcomes, most Important *TO/FOR* the person, potential Risks and any Rights restrictions. A more detailed description follows the example form on the next page.

Person Centered Plan — Summary

Status: In Progress

Plan Type: Annual PCP

Overview Information

Client Details

Participant Name: Harry Dell
 Nickname/Also Known As:
 Date of Birth: 12/31/1960
 Client ID: 969696
 MA Number: 4563214563
 Primary Phone #: (333) 333-2222
 Current Address: 1234 Mystreet Lane, Mycity MD 44444



Plan Details

Program Type: CP
 Annual PCP Date: 04/10/2019
 Plan Type: Annual PCP
 Is Urgent? No

Meeting Date: 12/14/2017
 Create Date: 12/22/2017
 Effective Date: 04/19/2018
 End Date:

Plan Contacts

Role	Name	Contact Number	Email
Brother	Jerry Dell	(333) 333-5555	jerrydell255@gmail.com
Sister	Harriet Sparks	(333) 888-7777	harriettsparks@verizon.net

Summary

What I like and Admire about Myself:

People say I am energetic, I love my family, I work very hard to do a good job for my employer

What I am Interested in Doing:

I like my current job but would be interested in something that pays more.

Important People in My Life:

My brother and sister are the most important people in my life. Also important is my best friend, John.

Best Way to Communicate with Me:

Email is preferred, be clear and spell things out for me and make sure I understand

Technology I use:

Smartphone

Outcomes

Category	Outcome	Outcome Description	Requested Services
My Choices	People choose where they work	Harry has a job he enjoys where he makes at least \$12.50 an hour	Employment Discovery

Important To Me

Rank	Important To Me	Focus Area
1	To earn enough money for doing things I enjoy	Employment
2	To be understood by others	Communication
3	Opportunities to develop new skills	Lifelong Learning

Important FOR Me

Rank	Important For Me	Focus Area
1	Learn money-management skills	Finance
2	Stress/anxiety reduction measures	Health Wellness

Risks

Risk Name	Description	How Addressed	Restriction	Focus Area
Stress/feeling overwhelmed	Sometimes won't share stress; feels it is a sign of weakness	Have support of family		Communication

Rights Restrictions

Rights Restriction	Related Specific and Assessed Need	Description of Condition	Positive Interventions and Less Intrusive Methods Tried	Timeline to Monitor /Review Effectiveness
Choice and control	Stress management	Becomes stressed when schedule demands prevent sufficient rest or alone time	Weekly schedule in advance; notice of changes	Follow up quarterly

Note: Forms as shown are based on the LTSS at the time of this publication and are subject to

Demographic information from Client Profile

The **Annual PCP Date** is chosen by the person when the initial PCP is developed. **Created Date** refers to the most recent version and is auto-generated. **Effective Date** is the date the current PCP (or revision) is authorized for implementation.

Introductory questions about the person and his/her interests

All selected *Outcomes* are listed on this page.

Important To/For pulls from what is entered in the FAE sections in LTSS; further items may be added here and included in the ranking.

Risks can be added and ranked at the summary level. Any identified *Rights Restrictions* will require additional information.

To further understand the content of the PCP Summary, in addition to demographic and general information, it includes:

- List of Outcomes for the current plan year:
 - Outcome category: Selected from FAE data using Personal Outcome Measures® (POMs)
 - Outcomes: Selected from FAE data using POMs
 - Outcome Description: Statement to describe in detail what the person wants to happen as the result of related supports and services
- Quick Summary of what is Important TO and FOR the person:
 - Rank: Identified during Exploration; may be during the planning meeting
 - Important TO me: Elements of life that are valued by the person and contribute to his or her happiness and/or contentment; identified from the FAE
 - Important FOR me: Needs that should be addressed to support a person's health and safety; identified from the FAE
 - Discovered in (Focus Area): Section of the FAE where information was captured
- Quick Summary of risks and how they will be addressed: This section is based on information from the FAE and automatically populated when completed
 - Risk name: Potential hazard related to supporting a person's desired Outcome or to not addressing a person's support need
 - Description: Summary of why there is a risk
 - How addressed: Specific actions to mitigate or minimize the risk
 - Rights restriction: Any potential limit of a person's fundamental rights as described in COMAR 10.22.04/.05/.10 (see also *Definitions* section for list of service-related rights)
 - Discovered in (Focus Area): Life Domain section of the FAE where this information is captured
- Quick Summary of Rights Restriction:
 - Rights Restriction: Specific right that is or may be restricted (see *Definitions* section for list)
 - Related and specific assessed need: Describes the risk being mitigated by the potential restrictive measure
 - Description of condition: When and how the restrictive measure is applied; note status of due process steps (outlined in *Definitions* section)
 - Positive intervention and less intrusive measures tried: Brief description required to justify use of a restrictive measure
 - Timeline for monitoring/reviewing effectiveness: Note how and how often team is to review use of the restrictive measure
- Picture: This can be a photo of the person or any other picture that he or she chooses.

“What matters most to people's safety is the extent and quality of their relationships.”
–John O'Brien

The Outcome Detail

Using Discovery information, the person can be guided to identify personal Outcomes for the year from the list of CQL⁷ POMs. The Outcome Category helps to bring focus to the selection:

⁷ The Council on Quality and Leadership (CQL) provides training, accreditation and consultation to human service organizations and systems that share their vision of dignity, opportunity and community for all people. The CQL Personal Outcome Measures® are a tool to ensure supports and services are person-centered. For more information, go to <https://www.c-q-l.org/the-cql-difference/personal-outcome-measures>.

- My Security = No-negotiable human and civil rights
- My Community = Access to be in, a part of and with the person's local community
- My Relationships = Social support, intimacy, familiarity, and belonging
- My Choices = Decisions about one's life and community
- My Goals = Dreams and aspirations about the future

Outcomes			
Outcome Category: My Choices			
Outcome: People choose where they work			
Relevant Focus Areas(s): Employment, Lifelong Learning, Finance			
Description Of Outcome: Harry has a job he enjoys where he makes at least \$12.50 an hour			
Requested Services to Support Outcome: Employment Discovery			
Projected Start Date: 04/19/2018		Projected Completion Date: 04/19/19	
Related Important TO Me		Related Important FOR Me	
To earn enough money for doing things I enjoy		Learn money management skill	
Opportunities to develop new skills			
How are community resources and/or natural supports being used or developed? Reaching out to family and local businesses for employment ideas and opportunities			
Technology I need to support this outcome? Smartphone e-scheduling app			
Outcome Progress Review - The team will know progress is occurring when:			
What does progress look like to me? I have met with a minimum of 3 possible employers			
What does progress look like to my team? Harry has had 3 job interviews and one offer			
What is the frequency that is planned to support my outcome?			
Assessing Satisfaction	Assessing Implementation Strategies	Outcome Review	
Quarterly	Monthly	Quarterly	
Support Considerations			
Natural/Community/Other Contributing Resources to Support Outcome			
Support Person	Relationship	Support Role	Phone Num
Jerry Dell	Brother	Introduce Harry to work colleagues in his company	(333) 444-555
Mr Jones	Bank employee	Arrange for tour of bank and meet with departmental supervisors	(333) 999-888
Non-DDA Funded Resources to Support Outcome			
Program	Support/Services	Agency	Contact Pe
Ride Share	Transportation	Virgo Van Pool	Shelly Duval

My Security:

- People are safe
- People are free from abuse and neglect
- People have the best possible health
- People experience continuity and security
- People exercise rights
- People are treated fairly
- People are respected.

My Community

- People use their environments
- People live in integrated environments
- People interact with other members of the community
- People participate in the life of the community

My Relationships

- People are connected to natural support networks
- People have friends
- People have intimate relationships
- People decide when to share personal information
- People perform different social roles

My Choices

- People choose where and with whom they live
- People choose where they work
- People choose services

My Goals

- People choose personalized goals
- People realize personal goals

- Relevant focus area(s): Based on related Life Domain section in the FAE section of LTSS
- Description of Outcomes is a statement to further define what the person wants to happen as a result of the supports, to include person-specific benefit or value.
- Requested Services to Support Outcomes are those provided by DDA through one of its Waivers.
- Projected Start Date: Support for Outcomes will start on this date.

- Projected Completion Date: Date the Outcome is expected to be achieved
- Related Important TO/FOR me: In accordance with the FAE information in LTSS for this Outcomes
- How are community resources or natural supports being used or developed? Identify and describe opportunities for including non-staff in the Outcome-related activities, to include use of generic community resources (i.e., using a store-provided shopping aide or having staff focus on developing relationships with coworker's versus providing actual on-the-job assistance).
- What technology do I need to support this Outcome? In addition to identifying needed technology such as communication devices or adaptive equipment, technology used to support Outcomes can include those used by most people, i.e. smart phone for reminders or GPS device for navigating the community.
- In what way will the team know that progress is occurring?
 - *What does progress look like to me?* This is key to determining whether supports are effectively helping the person to achieve the Outcomes as articulated and agreed upon. This should be stated in the person's own words as much as possible and guides monitoring for satisfaction.
 - *What does progress look like to my team?* As noted above, the clarity of this section is critical to the monitoring of effective implementation of the PCP. This section should be fully guided by the person's desires and timeline for achievement of the specified Outcomes.
 - *How and how often will progress towards these Outcomes be reviewed?* Monitoring is done face-to-face and quarterly at a minimum; short-term or newly identified Outcomes may need more frequent review to assure intended direction toward attainment.
- What is the frequency that is planned to support my Outcome?
 - *Frequency for assessing satisfaction*: How often will the person's satisfaction be assessed?
 - *Frequency for assessing implementation strategies*: This may be more appropriately done by the service provider. There should be flexibility to revise strategies as indicated by the person's response.
 - *Outcomes review frequency*: Monitoring of Plan implementation, to include progress toward Outcomes, satisfaction with services, and verification of benefits must be at least quarterly.
- Each Outcome includes a Support Considerations section to note non-DDA supports for specific Outcomes. While all DDA services must be tied to at least one Outcome, not every chosen Outcome requires a service.
 - Natural/community/other contributing resources to support Outcomes:
 - *Support Person* - Such as a family member, co-worker or other natural support
 - *Support Role* - What the support person is doing to promote achievement of the Outcomes
 - Non-DDA resources to support Outcomes:
 - *Agency* - Generic community resources used, such as DORS, CFC, REM, housing voucher programs, and education aides
 - *Support* - Describe specific type of support being provided, including contact information

"There is power in the team process!"
 –Ken Capone

The Service Authorization

This is information needed by DDA in order to assess the services proposed for implementation of the PCP. This is information related to DDA services requested to support an outcome **after consideration of natural, community, and other contributing resources and programs**. It is important to include supporting documentation related to the assessed need, frequency, and duration of the service to help facilitate DDA’s review and authorization. In the event that there is not enough information to make a determination, the DDA will send the CCS a request for additional information.

Signatures

It is important to keep in mind that there are at least three different signature pages, each specific to the role of the team member:

Individual or Authorized Representative/Guardian Signature Page – Person or the Authorized Representative/Guardian signs to indicate consent to and agreement with the PCP as written.

CCS Signature Page – CCS signs to verify their role in facilitation and development of the PCP and agrees to monitor as indicated.

Provider Signature Page – Representative of the provider agency signs to promise delivery of services as outlined in the Service Authorization. Each provider agency signs a separate Provider signature page.



MARYLAND
Department of Health

Individual Signature Page

Plan Information

Name:
 Nickname/Also Known As: Alexander
 LTSS ID#: 22092R4AURE8111
 Plan Type: Initial PCP
 Plan Create Date: 12/22/2017
 Annual PCP Date: 04/10/2019
 Assigned CCS Coordinator:

This plan only approves services for the CP and is subject to DDA approval. Funding and access to CP services for you is contingent upon you maintaining eligibility for the program.

Attestation

- By signing this plan, I certify that:
- ✓ I participated in making this plan.
 - ✓ If I am applying for or I am currently enrolled in the Self-Directed Services Program, I understand that I am the employer of record and that I have employer and budget authority.
 - ✓ I agree with the contents of the plan, including its documentation of my needs, goals and the service being requested for approval by the DDA.
 - ✓ I understand that I am free to:
 - Choose my person-centered planning team;
 - Choose from any qualified provider for my services;
 - Choose the service delivery method of either Self-Directed Services or Traditional Services; and
 - Request a modification of my plan based on if my needs change.
 - ✓ If there are restrictions in my plan, then I have consented to them per policy and regulation.
 - ✓ I have received information and understand how to identify and report potential abuse, neglect, and exploitation.

Services

Service Category	Service Title	Frequency	Duration	Scope
Meaningful Day	Employment Discovery & Customization (Transition Year)	Natural/Community/Other Contributing Resources to Support Outcome Natural/Community/Other Contributing Resources to Support Outcome Natural/Community/Other Contributing Resources to Support Outcome Natural/Community/Other Contributing Resources to Support Outcome	Natural/Community/Other Contributing Resources to Support Outcome Natural/Community/Other Contributing Resources to Support Outcome Natural/Community/Other Contributing Resources to Support Outcome Natural/Community/Other Contributing Resources to Support Outcome	Natural/Community/Other Contributing Resources to Support Outcome Natural/Community/Other Contributing Resources to Support Outcome Natural/Community/Other Contributing Resources to Support Outcome Natural/Community/Other Contributing Resources to Support Outcome

Signature

Sign Here: _____ Date: _____



EMPLOYMENT

Research reveals that work influences self-identity and perceived quality of life, both positively and negatively. Because society has historically assumed people with disabilities have little to offer in the workplace, many people may not understand the opportunities now available to them. You play a critical role in helping people to explore their professional interests and opportunities and create a framework for the team to support them. In keeping with Maryland's *Employment First* initiative, this Domain is required for Exploration and annual update to assure active and ongoing engagement promoting pursuit of paid work and career advancement. Be sure all required information is obtained during Discovery.

- **Employed** – If the person is currently employed, find out as much information about the job and wages as they are comfortable sharing. The FAE allows you to help the person create a resume of sorts, so you will want to know employer, job type, location, wage, schedule, length of employment, benefits, and duties. How does the person get paid? How do they get to work? Is public transportation a potential option? Assess satisfaction and interest in other types of work or potential for advancement in the current position. Find out what the person likes and does not like about the current job (i.e., wage/benefits, type of work, schedule, coworkers, supervisor, safety and security, appreciation, etc.).

“Working allows you to find out about skills you didn’t know you have. It gets you out of the house to be independent ... to learn and to communicate with others.”
-Macena, *Self-Advocate*

- **Not employed** – Is the person interested in working, and if so, what do they think they would like to do? If they have worked in the past, get the resume information noted in the section above and explore what they did and did not like about each job. Try to identify trends in preferred job tasks. If the person can do so, with or without support, have them describe a dream job. Encourage thought about money, schedule (i.e., some people feel strongly about having weekends off, or may prefer to work nights), and qualifications. Capture as many details as possible to help guide the team in providing support. Help the person to think about what may be needed to get the job they really want to have.

If the person is not interested in working, why not? Find out what the person does during a typical day. How much control do they have over what they do and where they go? What level of access do they have in the environment (bathrooms, appliances, tables/chairs, etc.) and to other people? Does the person have opportunities to spend time with people who do not have identified disabilities (other than staff), and how does the person seem to feel about this issue? Assess current satisfaction as well as prior experience with employment. If the person is retired, have they considered attending a senior’s program during the day?

- **Supports** – Identify level of support funded prior to discussion. Find out what support is being provided and how it is being delivered. Explore natural/unpaid supports that are being used to support current employment, as well as those potentially available but not being utilized. These might include family, friends, coworkers, and acquaintances who perform desirable work. Assess satisfaction and if additional supports would be needed to achieve an identified desired employment Outcomes.
- **Effective tools** to support Exploration in this area may include:
 - a) *My Places Connections Map* – Helpful for identification of potential links to job opportunities
 - b) *Preferences and Interests Helplist* – Helps the person to identify job-related preferences on a continuum

Resources

- ◇ **DDA Employment Services**
<https://dda.health.maryland.gov/Pages/employment.aspx>
- ◇ **Training Pack-New Paths to Inclusion**
 - <http://trainingpack.personcentredplanning.eu/index.php/en/communityconnecting/places>
- ◇ **DORS Website**
 - <http://dors.maryland.gov/Pages/default.aspx>
- ◇ **Maryland One Stop Career Centers**
 - <http://www.dllr.state.md.us/county/>
- ◇ **Charting the Life Course-Employment**
 - <http://www.lifecoursetools.com/wp-content/uploads/EMPLOYMENT-GUIDE-FINAL.pdf>



COMMUNICATION

Having the power to communicate and be understood is central to people having choice and control in their life. You must be aware of everyone's communication style and tailor Discovery accordingly. To maximize good planning, allow the discussion to be guided by the person whose PCP is being developed. Follow their lead and don't be in a rush to move to another topic if they want to tell you more about the current one. Relevant information should also be sought, with permission, from family members, direct support staff and other team members to gain additional perspective and insight.

- **Expression** – Learn about the person's primary way of communicating (i.e., speech, ASL, or communication device). Does their primary communication style change in different settings or around different people? Explore the level of information they will communicate to others; people they know and don't know. Are there any circumstances when the person would need someone to support their communication efforts? If the person does not consistently use speech or a device, describe the way they do communicate (i.e., body language, simple words/phrases, gestures, sounds) and complete a *Communication Map* (Appendix A) to capture the knowledge base of those who know the person best.
- **Emotion** – Explore the person's expression of feelings. Find out how they communicate daily needs as well as wants and desires. This is important regardless of basic expressive mode, as emotional responses are more complex and may be influenced by factors other than mechanics of speech. Can the person let others know they are hurt, angry, or afraid; or if they are getting frustrated? Are they more likely to tell only one specific person? Would they feel confident to say "no" if asked to do something dangerous or wrong?

Determine how and under what circumstances they will express personal preferences and level of satisfaction with services/supports provided to them.

- **Understanding** – Discover how the person wants others to communicate with them. What types of communication styles should be used and when (i.e., happy/sad, afraid, frustrated, excited, etc.). If you can have a conversation with the person, use reflection and restating to verify understanding on both sides. Identify the types of decisions he or she makes on their own vs. decisions made with support. How do we know which decisions are most important to this person? Find out what kind of experiences the person has had that would support the capacity to make informed decisions and/or choices.

“Person centered planning begins when people decide to listen carefully and in ways that can strengthen the voice of people who have been or are at risk of being silenced.” –John O'Brien

- **Technology** – Find out if the person uses typical technology such as cell phone, tablet, computer; explore their use of social media and if they don't manage their accounts, find out what support they get or need. See if there is any interest in learning more about technology or media options.
- **Effective tools** to support Exploration in this area may include:
 - a) *Communication Map* – Key information about how a person communicates; useful to guide others in understanding and responding.

Resources

- ◇ SDA Tool Kit - Go to Guide for Person-Centered Thinking Skills
 - <http://sdaus.com/toolkit>
- ◇ Training Pack-New Paths to Inclusion
 - <http://trainingpack.personcentredplanning.eu/index.php/en/person-centred-thinking-tools/communication-tool>
- ◇ Helen Sanderson Associates-Communication Chart
 - <http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/communication-chart/>



LIFELONG LEARNING

Learning occurs throughout our lifespan; what a person wants or needs for continued growth will change throughout the planning process. Learning encompasses everything from personal or professional development, different ways of learning depending on the changing circumstances in the life of the person, different skill sets, and much more.

- **Learning style** – How does the person feel they learn best (listening, visual, modeling, classroom, one to one) for most things? Find out if they have a preferred time of day or environment for learning something new. Ask the person to describe a favorite teacher or mentor and what made that person effective?
- **Education** – Learn about the person's school experience; find out what they enjoyed most. Are they still in school; interested in attending school? If so, explore what they would like to achieve and what supports may be needed. Be sure to consider supports offered by the school or training program.
- **Interests** – Explore general interests and potential for learning opportunities. Find out if they are interested in their personal development through something like peer mentoring, self-advocacy, rights and responsibilities, career exploration/training, or other areas. Would they like to join a self-advocacy group; develop leadership skills or become a mentor for others?
- **Supports** – Establish existing supports and discover what may be needed to encourage successful learning in the interest areas noted. These may include things like transportation, peer mentors, staff support, assistive technology, funding options, and accessibility services.
- **Effective tools** to support Exploration in this area may include:
 - *Know Your Rights* – Booklet developed to help people who receive DDA services better understand their rights and how to exercise them responsibly
 - *Learning Log* – Directs people to look for ongoing learning; captures learning details within specific activities and experiences

Resources

- ◇ People on the Go Maryland
 - <http://www.peopleonthegomaryland.com/>
- ◇ Maryland Developmental Disabilities Council
 - <http://www.md-council.org/>
- ◇ DDA Advocacy Support Unit
 - <https://dda.health.maryland.gov/Pages/Self-Advocacy%20Specialist.aspx>
- ◇ Disability Rights Maryland
 - <http://disabilityrightsmd.org/>
- ◇ Know Your Rights!
 - http://resconnect.org/media/docs/know_your_rights.pdf
- ◇ SDA Tool Kit - Go to Guide for Person-Centered Thinking Skills
 - <http://sdaus.com/toolkit>



COMMUNITY INVOLVEMENT

Community involvement is key to developing the social network that makes life interesting and vital. True inclusion happens when people live, work and play in their local communities with intent to participate in the give and take of community life. Community can mean different things to different people, so find out what it means to the person. Encourage exploration with people, family, staff and teams about the natural connections a person has and how they can be strengthened.

- **Preferences** – Try to ascertain what “community” means to the person. Because community participation is built upon social connections, find out what it means to others in their support network, especially family. Learn about the person’s favorite places to go and things to do. Capture preferences such as being in/outside; crowds or solitary/small groups; meeting new people or with friends only; day/night; seasonal and holiday activities; adventurous or comfortable and familiar. Find out how often the person has a choice as to when, where and with whom they go out. Also, note experiences the person clearly does not like, based on their experience. Explain what a “bucket list” is and see if the person may be interested in creating one; include who can help them.
- **Connections** – Learn about regular activities that may involve others, such as church membership/ministry; social clubs; family visits or vacations. Include banking, shopping, restaurants or specialty stores regularly visited; see if the person is familiar with people they regularly see in these places. With whom does the person celebrate holidays and birthdays? Is this by choice? Explore building a social network and adding people as they get to know them better.

Experiences and opportunities – Find out about specific experiences the person has had and things they have done, including their reactions to each. Complete the table titled *Being Active and Involved in my Community* (Appendix A), expanding as indicated through Exploration. Use it to explore potential new opportunities and activities to try. Learn about the person’s hobbies to determine if there is potential to share in the activity with others or to explore expanding their interest through classes or special interest groups/clubs. Explore how the person might be able to do more things and meet other people that share their interests; address potential barriers and supports needed (i.e. assistive technology, communication assistance, transportation, earning/having more money).

Find out whether the person’s experiences have allowed them to meet and/or be with people who do not have identified disability; find out how important this is.

- **Transportation** – The ability to participate in community life can be greatly impacted by transportation options. Is the person able to get to/from where they to go? What kinds of transportation do they use and do they have more than one option (paratransit, bus route, car service, agency car/van, family or friends)? Identify barriers to independent transportation and talk about interest in learning related skills.
- **Effective tools** to support Exploration in this area may include:
 - *Being Active and Involved in my Community* – Activity-specific list to explore and note experiences and responses; to assess expansion of opportunities
 - *My Places Connections Map and Relationships Map* – Both can identify who can help the person spend more time in preferred community places and activities
 - *Community Safety Checklist* – Simple assessment of acquired skills for maximum independence and safe unsupervised time covering four areas: Community Access; Home Safety; PO Medication Administration (review by RN); and Money Management. Generally completed by the person supported, family member, provider staff and CCS for increased validity
 - *A good internet search* – This will generate many of the local opportunities for things to do that support the persons known interests and having such information available for review during Discovery may provide a more robust set of options for planning; a few site suggestions are noted under *Resources*.
 -

Resources

- ◇ Google – Keyword search to identify local resources such as parks and recreation, the chamber of commerce, public library, museums, music venues, etc.
- ◇ Meetup – An online social networking portal that facilitates local offline group meetings; allows members to find and join groups unified by a common interest, such as politics, books, games, movies, health, pets, careers or hobbies.
 - <https://www.meetup.com/>
- ◇ Visit Maryland – Updated information about statewide activities and events
 - <http://www.visitmaryland.org/>



DAY to DAY

In our day-to-day lives, the details involving personal care, mobility, meals and food, taking care of our homes, as well as our own personal safety are of the utmost importance to the quality of our lives. In this category, you have an opportunity to ascertain both the details and the priority levels of each of these areas as they relate to the person’s life.

- **Free time** – Find out what the person does when not at work or a structured day program. What kinds of things does the person do? What do they enjoy most/least? Are weekends different than week nights and if so, how? How are these things decided and by whom? Learn about household duties, as well as hobbies and special interests. If there are none identified, explore what the person has tried to see what opportunities might be further developed, as well as discussing things of interest they may have seen others doing and would be willing to try.
- **Supports** – Maximum control and choice in daily life may be influenced by the level of support needed to do what one wants to do. Find out what paid and natural supports are available and how they are used on a regular basis. Does the person have skills to support safe, unsupervised time? Have home and community safety skills ever been assessed? This should cover mobility, meal preparation, emergency response, pedestrian/street safety and interacting with others.

- **Access** – In discussing daily life, capture what the person does for themselves; determine involvement in meal preparation, personal care and transportation. What is the person’s desired level of independence in these areas? Is additional support or training indicated? Are personal care supports needed? If support is provided, assess sufficiency and satisfaction. Note special or adaptive equipment needs, home accessibility status and transportation options.
- **Shopping** – Having the ability to shop for the things needed and wanted can promote great satisfaction; it also requires a complex set of skills that can be taught, supported or a combination of both. Find out what type of shopping the person does; ask for their description of what/how often/who helps/where do they go. How do they get to the store; who makes the list and who handles the money? Do they enjoy shopping? Do they ever use the internet to shop? Talk about what supports are desired/needed for a safe and enjoyable experience.
- **Effective tools** to support Exploration in this area may include:
 - *Rituals & Routines* – Learn specifics of these times and events to better understand what is Important TO/FOR the person, and what daily supports they most appreciate.
 - *Good Day/Bad Day* – Identify specifics of a good and bad day for the person, so planning can maximize good days and minimize effects of bad days

Resources

- ◇ SDA Tool Kit - Go to Guide for Person-Centered Thinking Skills:
 - <http://sdaus.com/toolkit>



FINANCE

Money and the decisions we make regarding how we use it greatly impacts our lives. It affects how we live, socialize, work, play, and even access healthcare. Our choices about money will control when we retire and the care we receive as we age. Financial responsibility requires support based on clear understanding of personal goals and opportunities to learn about how to budget, save, spend; each person having maximum and increasing control per his or her ability.

- **Financial function** – Determine benefits and verify amounts (SSI; SSDI; Medicaid and waiver enrollment status; food stamps; pensions; trusts), as well as wages and employee-related benefits, to effectively explore adequacy and planning needs.
- **Control and access** – For the person who is employed, find how their wages are received and disbursed. Find out how the person gets personal spending money and if done through paid support, explore the person’s knowledge of their funds and the steps they take to gain access. Find out if the person has a checking or savings account and their level of control for each. What is the person’s understanding of their personal finances? Do they contribute toward household expenses; have bills for healthcare services or debt that must be paid? Find out how decisions are made regarding their money and any personal assets.
- **Support** – Learn how personal funds are budgeted; who helps and what kind of help is provided. See if regular statements or other reports are provided, or if they can help the person to better understand and learn how to manage their money. If this is not being done, why not? Is this something they want to learn about? Explore what is most important to the person regarding their money and how it is handled.
- **Planning for the future** – Is the person aware of the benefits for which they are eligible? Find out if they would like to know more. This may influence planning as they work with

their team to consider setting up a trust, obtain insurance or being able to retire. Explore plans to save in the coming year for something the person wants to purchase or a special activity/travel/vacation. Assess level of interest and potential cost to facilitate useful discussion and planning with the support team.

- **Effective tools** to support Exploration in this area may include:
 - *EVS* – Verify status of Medicaid eligibility and Waiver enrollment.
 - *Community Safety Checklist* – This is a simple assessment of acquired skills, including Money Management; generally completed by the person supported, family member, provider staff, and CCS for increased validity.

Resources

- ◇ Maryland Medical Programs Web Services
 - <https://encrypt.emdhealthchoice.org/emedicaid/>
- ◇ Social Security Administration
 - <http://www.ssa.gov/>
- ◇ Maryland Health Connection – Apply for health insurance, including Medicaid
 - <https://www.marylandhealthconnection.gov/>



HOME AND HOUSING

Many of us spend a lot of our time at home. For some it represents sanctuary and safety in a big world. We must be aware of what people like, dislike, need, and their hopes and dreams regarding their living situation. Meaningful lives are made up of any number of details that matter mostly to the individual; no matter how large or small they may seem to others. These details could make the all the difference in a person's life.

- **Housing** – Find out prior to the interview if the person has residential services and if so, you should know the type and number of hours daily/weekly. During Discovery with the person and team, try to assess whether the level of support feels adequate to the person; or if they need supports they are not currently receiving. If the person is being served in a licensed setting, find out how they were involved in choosing where they live and with whom; assess current satisfaction.
- **Home** – Explore how the person feels about their living situation in general; location, other's sharing the house, access to the home and community, and other related topics that arise. Find out if they know their neighbors, have a house key, open their mail or decorated their room. Does it appear they would like anything to be different? If so, see if they can share how their idea of "home" differs. What changes would they make if they could?
- **Support** – Learn about individual choice and control over routines (like eating, sleep, TV, quiet time or house activities). Does it seem that more choice could be promoted in any area? Does the person have responsibility in the household such as cooking, shopping, laundry, other general household tasks and who helps them do these things (or are they done for them)? Are there additional supports that could promote more choice and independence, such as home modification or assistive technology?
- **Privacy** – Privacy may be impacted by family culture or, for the person receiving support in a residential site, by preferences of other residents in the house. It is important that you also respect the privacy of the person you are helping to plan and that you are sensitive to what may be said about other people in this discussion. Find out how the person defines privacy for themselves and whether they feel respected in this area. Discussion should include whether the person is able to control things related to self, such as who enters their bedroom/bathroom and why; limits on visitors/mail/email/phone

access; access to personal information (is it posted for all to see?) and who makes the decisions about these things.

- **Future planning** – Having learned about where the person is currently, spend some time exploring their hopes for the future. What changes might they like to work toward and what do they want to stay as is? What do they want other people to know about their desires in this area.
- **Effective tools** to support Exploration in this area may include:
 - *Rituals & Routines* – Learn specifics of times or events to better understand what is Important TO/FOR the person and what daily supports they most appreciate.
 - *Community Safety Checklist* – Simple assessment of acquired skills for maximum independence and safe unsupervised time covering four areas: Community Access; Home Safety; PO Medication Administration (review by RN); and Money Management. This is generally completed by the person supported, family member, provider staff and CCS for increased validity

Resources

- ◇ Maryland Section 811 Program:
 - <http://mdod.maryland.gov/housing/Pages/section811.aspx>
- ◇ HUD in Maryland:
 - <http://portal.hud.gov/hudportal/HUD?src=/states/maryland>
- ◇ Affordable Housing in Maryland:
 - <http://affordablehousingonline.com/housing-search/Maryland/>
- ◇ Housing Assistance Programs:
 - <http://www.maryland.gov/pages/residents.aspx?view=Housing>
- ◇ Maryland Access Point: An online, searchable resource directory to serve the public and professionals in identifying, connecting and accessing private and public resources
 - https://marylandaccesspoint.info/consumer/explore/home_and_community/
- ◇ SDA Tool Kit - Go to Guide for Person-Centered Thinking Skills
 - <http://sdaus.com/toolkit>



HEALTH AND WELLNESS

Maintaining good health is essential for most people to live the way they choose. You should not only be aware of preferences, but also monitor and advocate consistently to ensure that health needs are being met, to include supported healthcare decision making. Studies show that people with disabilities have better health outcomes when they are involved in decision making. With adequate planning, as well as the right combination of supports from a network of family, friends, the disability service system, and others, people can develop a personal vision for their current and future healthcare.

- **Personal health** – Find out how the person feels physically; if there have been any changes that cause concern. Determine how the person is supported when not feeling well and what preventative measures are routinely taken (i.e. flu shot; annual exams)
- **Healthy lifestyle choices** – Explore understanding of and attitudes about doing things to stay healthy or promote improved health. Does the person smoke, follow a diet or exercise? Be careful of judging or being preachy based on your personal feelings in this area. While it is important to develop healthy habits, respect for personal choice is paramount. Offering support, ideas, and resources can be a delicate undertaking for someone who is not ready to make changes. Learning where the person stands is a starting point.

- **Personal feelings about health and healthcare** – Learn about the doctors and other healthcare professionals serving this person; do they especially like one of them? Are the services helpful? Are recommendations explained in ways they understand, and how seriously are recommendations taken? Be open to hearing if there is any concern about one or more doctors the person sees. Determine potential barriers (such as transportation, support during appointments or fears). You may want to see if additional referral sources are needed to maximize comfort with and utilization of services.
- **Access to healthcare** – Find out about support needs for doctor visits and other therapies; such as how healthcare services are coordinated and by whom. Assess the person’s understanding of prescribed medications (what is taken/why/potential side effects) and what supports are available to promote improved competence if indicated.
- **Advance directives** – Learn about their healthcare decisions; who does the person rely on? Does the person feel they have a say in these decisions? How important is this to the person? If you know there is an advance directive, find out if a review is desired. If there is no advance directive, assess which of the many options would be most helpful and find out who the person may want to help with completion.
- **Effective tools** to support Exploration in this area may include:
 - *Relationship Map* can help the person figure out who they would select to make healthcare decisions when/if they are unable to do so (appointing a Healthcare Agent is part of the Advance Directive).
 - *Five Wishes*® is an advance directive/living will that explains options in plain language and presents questions in ways most people can understand so their choices are clear. The completed document meets state requirements for a formal and legal healthcare directive.
 - A *Maryland Advance Directive* form can be used to make multiple healthcare choices and is available online for completion and printing. Advance Directive for Mental Health Treatment allows a person to plan when able for times of decompensation so that treatment options are more self-directed. Maryland offers all allowable forms, along with information for deciding which and how to use each at <http://www.marylandattorneygeneral.gov/Pages/HealthPolicy/AdvanceDirectives.asp>

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Resources

- ◇ Vaccines and healthcare milestones:
 - www.vaccines.gov ; www.nlm.nih.gov : www.ahrq.gov
- ◇ Arc Center for Future Planning:
 - <https://futureplanning.thearc.org/>
- ◇ Maryland Advance Directive:
 - <http://www.caringinfo.org/files/public/ad/Maryland.pdf>
- ◇ Five Wishes Online:
 - <https://fivewishesonline.agingwithdignity.org/>



RELATIONSHIPS

All people need meaningful relationships for general health and well-being. Too often, people with disabilities are not supported to create and develop meaningful connections. Instead, the focus of relationships center around paid staff or service providers. It is important to regularly assess the quantity, quality and diversity of relationships in which the person is valued for who he or she is and to determine the level of choice the person has in making and maintaining these relationships. Opportunities to meet and relate in meaningful ways with people outside of the service system are critical to forging natural and lifelong

connections. Gathering information about relationship preferences can help the team better understand the person and promote “thinking outside the box” about opportunities to enhance and maintain current relationships, while supporting development of natural relationships base on shared interests and enjoyment.

- **People in general** - Find out what the person would want others to know about him or her, and how many people in his or her life know these things. Who are those people? Do they spend a lot of time together; enough time? If only paid/staff are noted, find out how long those people have in the person’s life. Is the person happy with those relationships; are there concerns? What kinds of things do they do together? Explore some of their regular activities (i.e. church, gym, clubs), and places visited (i.e. stores, bank, restaurants) to determine the level of interaction with others. Also, assess and consider the personal level of satisfaction.
- **Friends** – Find out how much time the person spends with their friends. How do they define “friend”? Is there a “best friend”? Explore what kinds of things they do together and if there are any barriers that prevent them from doing things they want to do or spending more time together if that is desired.
- **Family** – Learn the same kinds of things about family. Be sure to first see if the person wants to discuss the quality of those relationships.
- **Intimacy** – This is an area the person may not want to discuss, even if you know each other well. Follow their lead. Take care to be respectful in asking questions. Be aware of the person’s comfort level. Find out what is okay to include or not include in planning documents. Just knowing whether the person is happy with their situation or with a “boy/girl-friend” relationship may be sufficient, unless the person indicates otherwise.
- **Important** – Does the person indicate satisfaction or frustration in any of these areas? Are there opportunities to build on any of the identified relationships? Does the person want more friends ... greater intimacy with just a few people? If so, what are the perceived barriers; why is this not happening now? See what ideas the person and their support network have about expanding the circle of people in their life and who might be helpful in furthering those efforts.
- **Effective tools** to support Exploration in this area may include:
 - *Relationship Map* – Creates a picture of who is in the person’s life
 - *Matching* – Structured look at people characteristics to help people think about the kind of people they want/need supporting them

“The ultimate success of a service system depends upon its ability to help people to maintain and develop positive, enduring, freely chosen relationships”. - John O’Brien

Resources

- ◇ The Facts of Life ... Plus – Quarterly newsletter about social development, sexuality and intellectual disability by Leslie Walker-Hirsch, recognized expert in social and sexual development for people with intellectual disabilities:
 - <http://www.lesliewalker-hirsch.com/newsletter/>
- ◇ The Five Valued Experiences – described by John O’Brien, a pioneer in and lifelong advocate of Person Centered Planning:
 - <https://cincibility.files.wordpress.com/2012/08/five-valued-experiences.jpg> and <http://allenshea.com/wp-content/uploads/2017/02/FriendshipCommunity.pdf>
- ◇ Belonging by David Pitonyak:
 - <http://www.dimagine.com/Belonging.pdf>
- ◇ Loneliness is the Only Real Disability by David Pitonyak:

- <http://www.dimage.com/NASDDS.pdf>
- ◇ 7 Questions to Guide the Development of a Support Plan by David Pitonyak:
 - <http://www.dimage.com/page63.html>
- ◇ SDA Tool Kit - Go to Guide for Person-Centered Thinking Skills
 - <http://sdaus.com/toolkit>

Contributors

Allan Sheahan
Program Director
Service Coordination, Inc.

Barbara Huey
Support Broker and Advocate

Donna Retzlaff
Executive Director
Spring Dell Center, Inc/

Joyce Sims
Executive Director
Resource Connections, Inc.

Marc Weinstein
Central Region Director
Service Coordination, Inc.

Mary Anne Kane-Breschi
Director of Family Supports
Developmental Disabilities Administration

Mary Scott
Special Education Advocate
Family Member

Mat Rice
Self-Advocacy Specialist
People on the Go Maryland

Mindy Propst
Program System Director
Service Coordination, Inc.

Raychon Stroman
Quality Improvement Manager
Resource Connections, Inc.

Sharese Olatoye
Coordinator of Community Services
Resource Connections, Inc.

Teri Sparks
Director of Public Policy
Maryland Developmental Disabilities Council

Daniel Harlan
Consultant
Alvarez and Marsal

Edward Willard
Self-Advocate

Cindy Lindgren
Director for Quality Enhancement
Developmental Disabilities Administration

Janet Furman
Director of Provider Relations
Developmental Disabilities Administration

Jeanine Zlockie
Director of Communications and Education Programs
Nat'l Assn of State Directors of Developmental
Disabilities Services

John Butterworth
Institute of Community Inclusion
University of Boston

Kathleen Durkin
Executive Director
The Arc Baltimore

Ken Capone
Director of Public Policy
People on the Go Maryland

Kristina Hall
Participant and Policy Specialist
Maryland Department of Health, Community Options
Division

Nancy Pineles
Managing Attorney
Disability Rights Maryland

Patricia Sastoque
Program Director
Developmental Disabilities Administration

Rena Kosmides
Director of Technical Assistance
Maryland Association of Community Services

Rhonda Workman
Director of Federal Programs
Developmental Disabilities Administration

Stacie Jones
Supported Employment
Developmental Disabilities Administration

Terah Tessier, PhD.
Director of Individual and Family Support Services
Developmental Disabilities Administration

Yemonja Smalls. PhD.
State Director for Coordination of Community Services
Developmental Disabilities Administration

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